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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **MARIANNE KARLSEN, AKA** **MARIANNE OSER** **12109 Bambi Place** **Granada Hills, CA 91344** **Registered Nurse License No. 350170** Respondent.	Case No. 2013-978 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about September 30, 1982, the Board of Registered Nursing issued Registered Nurse License Number 350170 to Marianne Karlsen, aka Marianne Oser (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on December 31, 2013, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

STATUTORY PROVISIONS

4. Section 118, subdivision (b), of the of the Business and Professions Code ("Code") provides that the suspension/expiration/surrender/cancellation of a license shall not deprive the Board/Registrar/Director of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated.

5. Section 2750 of the Code provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

6. Section 2764 of the Code states:

> The lapsing or suspension of a license by operation of law or by order or decision of the board or a court of law, or the voluntary surrender of a license by a licentiate shall not deprive the board of jurisdiction to proceed with any investigation of or action or disciplinary proceeding against such license, or to render a decision suspending or revoking such license.

7. Section 2761 of the Code states:

The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

(a) Unprofessional conduct, which includes, but is not limited to, the following:

(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions

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8. California Code of Regulations, title 16, section 1442, states:

> As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life.

9. California Code of Regulations, title 16, section 1443, states:

As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5.

10. California Code of Regulations, title 16, section 1443.5 states:

A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided.

COST RECOVERY

11. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, with failure of the licentiate to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

SUMMARY OF FACTS

12. Beginning in 2006 to on or about February 19, 2010, Respondent was a nurse at Centinela Hospital Medical Center (Centinela Hospital) in the emergency room during the 0700 hours to 1930 hours shift.

13. On August 6, 2008, hospital staff had a conference with Respondent about her failure to maintain a patient's flow sheet between 1100 hours and 1800 hours.

14. On November 11, 2008, March 23, 2009 and June 1, 2009, hospital staff had discussions with Respondent regarding various issues, including her delay in transferring patients from the emergency room to the assigned rooms within thirty minutes, and her failure to complete patient transfer forms.

15. By 2010, Centinela Hospital's patient charting system was computerized. The vital sign machines were interfaced to the computer system. A nurse is unable to over-ride or backdate entries. The computer will record in real time when procedures are documented by the nurse. This recording is indicated as "Recorded Time" on the right side of the patient's chart. If, for example a nurse at 1430 hours documents a primary nurse assessment that was allegedly done at 1400 hours, the "Time Occurred" on the left hand side of the patient's chart will reflect the time the nurse alleges the assessment was done, i.e. 1400 hours, and the "Recorded Time" will reflect the actual time the nurse documented the procedure, i.e. 1430 hours.

16. On January 20, 2010, Centinela Hospital staff had a conference with Respondent about her failure to document the charts of two patients she discharged prior to her leaving the emergency room to attend a meeting. The nurse who covered Respondent's patients in her absence was not aware of two patients who were discharged by Respondent but remained in the emergency room. Following this incident, Respondent was advised by Centinela Hospital staff to maintain current and up to date documentation.

17. On February 11, 2010, Respondent was in charge of three patients: Patient 1, Patient 2, and Patient 3.[1]

[1] The patient's names are not being used to protect the patient's identity but will be identified by the medical record number during the course of discovery.

Patient 1

18. Patient 1 arrived at the emergency room at 1336 hours with complaints of chest pain, abdominal pain, nausea and vomiting. Patient 1 was triaged at 1356 hours, placed in a room by another nurse at 1415 hours, and then moved to another room under Respondent's care at approximately 1435 hours.

19. Respondent failed to document any primary nurse assessment from 1435 hours to 1930 hours. Respondent failed to document the taking of vital signs from 1435 hours to 1930 hours. Respondent's shift ended at 1930 hours and she eventually transferred care of Patient 1 to another nurse, Licensed Vocational Nurse (LVN) JV[2].

20. Respondent documented in Patient 1's chart at 2146 hours, well after her shift had ended, that she performed a primary nurse assessment at 1400 hours. Respondent documented in Patient 1's chart at 2147 hours, that she performed Intravenous (IV) Management at 1500 hours. Respondent also documented in Patient 1's chart at 2149 hours, well after her shift had ended, that she performed a Foley Urine Assessment at 1500 hours. A reassessment of Patient 1 was not done and documented by Respondent at least every two hours. All interventions, diagnoses and procedures were not done and/or were not documented in the patient record at the time they occurred.

21. LVN JV noted in Patient 1's chart that Respondent provided a change of shift report at 1930 hours, when her shift ended. LVN JV documented in Patient 1's chart at 2047 that he took the patient's vital signs at 1931 hours.

22. Respondent documented in Patient 1's chart at 2158 hours that she provided LVN JV a change of shift report at 2156 hours. Respondent failed to properly document time of discharge or transfer to another nurse. Such failure would show a hospital bed as full and would prevent Respondent from receiving an additional patient who needed care and treatment during her shift.

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[2] Hospital staff names are not being used to protect their identity but will identified during the course of discovery.

23. A doctor advised LVN JV that he could not review Patient 1's chart as nothing had been documented during Respondent's shift.

Patient 2

24. Patient 2 arrived at the emergency room at 1139 hours and was diagnosed with rectal bleeding, was triaged at 1142 hours by another nurse, and placed in a room under Respondent's care at approximately 1145 hours.

25. Respondent failed to document any primary nurse assessment between 1145 hours to 1930 hours. No vital signs were documented by Respondent between 1145 hours to 1930 hours. A reassessment of Patient 2 was not done and documented by Respondent at least every two hours. All interventions, diagnoses and procedures were not done and/or were not documented in the patient record at the time they occurred.

26. Respondent's shift ended at 1930 hours. At 1933 hours, after her shift had ended, Respondent documented that she performed a primary nurse assessment at 1200 hours but there was no proof of the vital signs being taken at that time in the form of the print out. At 1949 hours, Respondent documented taking vital signs at 1445 hours, at 1951 hours, Respondent documented taking vital signs at 1620 hours, and at 1952 hours, Respondent documented taking vital signs at 1700 hours but there was no proof of the vital signs being taken at that time in the form of the print out.

27. At 1925 hours, Respondent documented that the IV Management was done at 1200 hours. At 1926 hours, Respondent documented that the cardiac monitor was done at 1200 hours.

28. Patient 2 was returned to the emergency room under LVN JV's care because Respondent sent Patient 2 to the wrong floor and sent the patient's record to the wrong floor as well. At 0000 hours, LVN JV notes that "report was given to wrong floor and [patient] taken to that floor by previous nurse, [patient] was returned . . . [Patient] was never endorsed. Placed back on monitor." At 2300 hours, LVN JV notes in Patient 2's medical record that the patient was "never endorsed to [him]." Respondent failed to properly document time of discharge or transfer to another nurse at the time the patient was discharged or transferred to the care of another nurse.

Such failure would show a hospital bed as full and would prevent Respondent from receiving an additional patient who needed care and treatment during her shift.

Patient 3

29. Patient 3 arrived at the emergency room at 1431 hours with right hip and knee pain due to a fall, and was triaged by another nurse at 1501 hours.

30. A reassessment of Patient 3 was not done and documented by Respondent at least every two hours. All interventions, diagnoses and procedures were not done and/or were not documented in the patient record at the time they occurred.

31. At 2128 hours, after her shift had ended, Respondent documented that she placed Patient 3 in the room under her own care at 1510 hours. At 2138 hours, Respondent documented that she performed a primary nurse assessment at 1510 hours but there was no proof of the vital signs being taken at that time in the form of the print out. The primary nurse was not noted by Respondent in the patient's record until over six hours after the patient was admitted.

32. At 2154 hours, an oxygen respiratory assessment was documented by Respondent as having been done at 1510 hours.

33. At 2159 hours, Respondent documented providing a change of shift report to LVN JV at 1930 hours. Respondent failed to properly document time of discharge or transfer to another nurse at the time the patient was discharged or transferred to the care of another nurse. Such failure would show a hospital bed as full and would prevent Respondent from receiving an additional patient who needed care and treatment during her shift.

34. Following Centinela Hospital's investigation of Respondent's care of patients on February 11, 2010, Respondent was terminated by the Centinela Hospital on February 19, 2010.

35. On February 24, 2010, the Board received a complaint regarding Respondent's care of patients at Centinela Hospital on February 11, 2010.

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FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

36. Respondent is subject to discipline under Code section 2761, subdivision (a)(1), as defined under California Code of Regulations, title 16, section 1442, in that on or about February 11, 2010, while on duty as a registered nurse at Centinela Hospital, Respondent engaged in conduct that constituted an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent nurse, in her failure to properly document treatment and care of Patients 1, 2 and 3, and in her care, evaluation and assessment of Patients 1, 2 and 3. Such extreme conduct includes a repeated failure to provide nursing care as required, or a failure to provide care, or to exercise ordinary precaution in a single situation which Respondent knew, or should have known, could jeopardize the patient's health or life. Complainant refers to, and by this reference, incorporates the allegations in paragraphs 12-32 above as though set forth fully.

SECOND CAUSE FOR DISCIPLINE

(Incompetence)

37. Respondent is subject to discipline under Code section 2761, subdivision (a)(1) on the grounds of incompetence as defined under California Code of Regulations, title 16, sections 1443 and 1443.5, in that Respondent did not possess and/or failed to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse in her failure to properly document treatment and care of Patients 1, 2 and 3, and in her care, evaluation and assessment of Patients 1, 2 and 3. Complainant refers to, and by this reference, incorporates the allegations in paragraphs 12-32 above as though set forth fully.

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THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

38. Respondent is subject to discipline under Code section 2761, subdivision (a), in that she engaged in unprofessional conduct in her failure to properly document treatment and care of Patients 1, 2 and 3, and in her care, evaluation and assessment of Patients 1, 2 and 3. Complainant refers to, and by this reference, incorporates the allegations in paragraphs 12-32 above as though set forth fully.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 350170, issued to Marianne Karlsen, aka Marianne Oser;

2. Ordering Marianne Karlsen to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: April 26, 2013

Louise R. Bailey

LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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